

**TESTIMONY SUBMITTED TO
THE HOUSE ENERGY AND COMMERCE COMMITTEE
SUBCOMMITTEE ON HEALTH**

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**“UNINSURED CHILDREN:
MISSED OPPORTUNITIES FOR MOVING FORWARD”**

Good morning, Mr. Chairman, and members of the Subcommittee on Health. I am honored to have the opportunity to share my experience and passion for covering kids. For the record, my name is Tricia Brooks. It has been my privilege to serve as the President and Chief Executive Officer of New Hampshire Healthy Kids Corporation (NHHK) since its inception in 1994.

NHHK is a legislatively-created nonprofit dedicated to providing uninsured children with access to affordable, quality health coverage. Although our legal status is a private, not-for-profit organization, NHHK is considered a state instrumentality performing important functions of state government. As stipulated in New Hampshire statute, NHHK serves as the SCHIP administrator. Our volunteer Board of Directors includes six representatives of state government including appointments by the Governor, Speaker of the House, Senate President and Commissioners of Insurance, Education and Health & Human Services.

Under a cooperative, contractual partnership with the New Hampshire Department of Health & Human Services, NHHK leads the effort to educate the public about children's health coverage options and to assist families in applying for coverage. NHHK directly administers the

premium-based SCHIP/Title XXI program through insurance subcontracts. Our headquarters in the state capital serves as the mail-in application and enrollment center for both Medicaid and SCHIP which are known as Healthy Kids. I am not an official state representative but having administered the SCHIP program for the past decade, I am knowledgeable about all programmatic aspects and the impact of federal policy on our program.

NHHK began covering kids four years prior to SCHIP so I know first-hand what the federal partnership has meant to our state. My organization's success in its early years was inhibited by one constraint – a lack of funding. We made great strides in increasing awareness of the importance of medical insurance to children's health and performance in school. We created a terrific health plan that focused on the preventive and primary care that kids need most. We fostered essential partnerships with hospitals and healthcare providers to keep the cost of services low. We engaged schools and social service agencies to help us identify and enroll children. But without funding to subsidize premiums, participation remained out of the financial reach of many families. This all changed when Congress established SCHIP.

It was unequivocally the influx of federal dollars that spurred New Hampshire's progress in covering kids – progress that reduced the percentage of uninsured children in New Hampshire by half from 10.8% in 1993 to as low as 5.2% in 2003. Like many states, our uninsured rate has increased in recent years to about 6.3% based on the latest data.

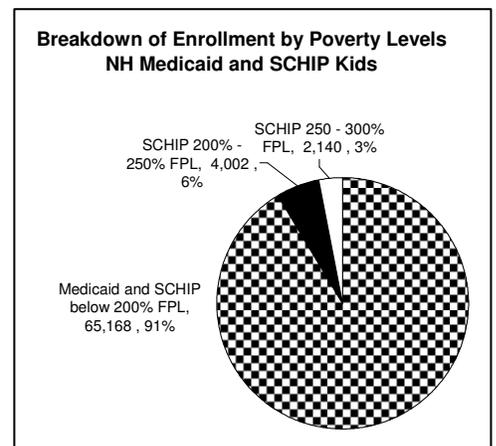
Although a fiscally conservative state, New Hampshire has made children's health coverage one of its top public policy priorities. From establishing a non-profit dedicated to the mission of advancing children's coverage to the design of our SCHIP program, our state has taken practical, cost-effective steps to expand children's access to insurance. We were purposeful in creating our SCHIP program to be responsive to the needs of workers and self-employed families who

want to insure their children but cannot afford coverage in the private market and to families who encounter disruptions in employment and income. In doing so, it was imperative that we address the high cost of living and high cost of insurance in our state by covering kids up to 300% of the federal poverty level (FPL). This eligibility level was approved by the Centers for Medicaid and Medicare (CMS) in our original SCHIP plan and has enhanced our efforts to enroll low income children in Medicaid. Today our programs are as follows:

- Medicaid is a state-run fee-for-service program that covers pregnant women and children under the age of 19 in families with income up to 185% FPL.
- Infants under the age of 1 with family income up to 300% FPL are covered as a Medicaid expansion group using SCHIP funding.
- SCHIP provides a private, managed care health plan to uninsured children with premiums based on a sliding income scale:
 - 185% and 250% FPL – \$25 per child per month (\$100 family maximum)
 - 250% and 300% FPL – \$45 per child per month (\$135 family maximum)
- Families with income between 300% and 400% FPL and others who do not qualify for Medicaid or SCHIP can buy into the SCHIP group benefit plan for an unsubsidized cost of \$165 per child per month.

Currently over 71,000 children are covered by Medicaid and SCHIP. This chart clearly shows that our low income children are well served:

- 91% of enrolled children have income below 200% FPL
- 6% are between 200 and 250% FPL
- 3% are between 250% and 300% FPL



Since much of the debate around SCHIP reauthorization has focused on whether the lowest income children are covered first, it is appropriate to point out that our outreach and application assistance efforts enroll pregnant women and children in Medicaid at much higher rates than SCHIP. Of every eight new applicants enrolled by our mail-in application center, six children and one pregnant woman are eligible for Medicaid and one child is enrolled in SCHIP. These results clearly indicate that despite high eligibility levels and separate Medicaid /SCHIP programs, a seamless and coordinated approach to outreach and application assistance is clearly effective in serving the lowest income children first.

With that background let me turn to the issues at hand. After celebrating Congress's success in passing the bipartisan CHIPRA bill last year, I am discouraged that progress has been thwarted by the President's subsequent vetoes. While there are certainly missed opportunities for continuing to move forward in covering kids, I am equally – if not more – concerned about losing ground if Congress does not intervene.

Although Congress extended the current SCHIP program with sufficient funding to offset expected state shortfalls, states are being stopped from taking full advantage of flexibility allowed under the current SCHIP rules by CMS. Furthermore, a number of states face the untenable task of cutting back their programs as a direct result of the so-called "August 17 CMS Directive." This directive which was issued arbitrarily without any public process came out of the blue. It was a shock to our state given that it overturned the long-standing rules under which New Hampshire has operated its program since 1998.

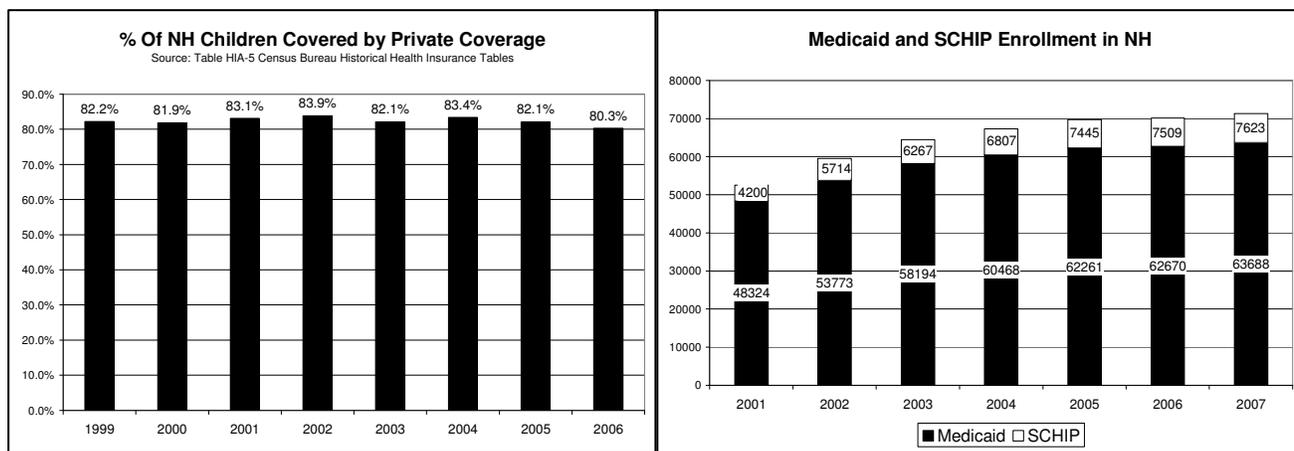
The directive establishes preconditions that fundamentally make it impossible for states to continue to cover children in families with income above 250% FPL:

- First, each state must prove that it has enrolled at least 95% of children in the state below 200% FPL who are eligible for Medicaid or SCHIP. This is an unrealistic standard for a means-tested program where people have to apply and be reviewed at least annually for eligibility. Even Medicare which automatically enrolls people without any means-testing has a participation rate of only 95%.
- Second, each state must ensure that employer-sponsored coverage of children has not declined by more than two percentage points over the past five years. This precondition disregards the fact that states have little control over trends in employer based coverage which have resulted in sharp declines in coverage for workers and their dependents.

Had CMS sought input from program administrators or policy experts, they would have quickly learned that setting unreasonable benchmarks for which no reliable data exist makes preconditions for covering kids above 250% FPL unattainable. Beyond meeting the preconditions, rigid eligibility criteria presents additional barriers for families. A one-year waiting period with no exceptions denies access to a child whose parent has died or lost a job. Imposing cost-sharing comparable to the private market means eligible families cannot afford to participate.

In the Northeast and on the West Coast, in large metropolitan areas and elsewhere, the ability to cover kids in families with income greater than 250% FPL is necessary to equalize regional differences in the cost of living. 250% of poverty is \$42,948 for a family of three. Based on the available data, the cost of living in New Hampshire is between 15% and 39% higher than the national average. By ignoring this fact and not giving administrators the flexibility to design programs to meet the individual needs of their states, CMS is in effect discriminating against working families in high cost of living areas.

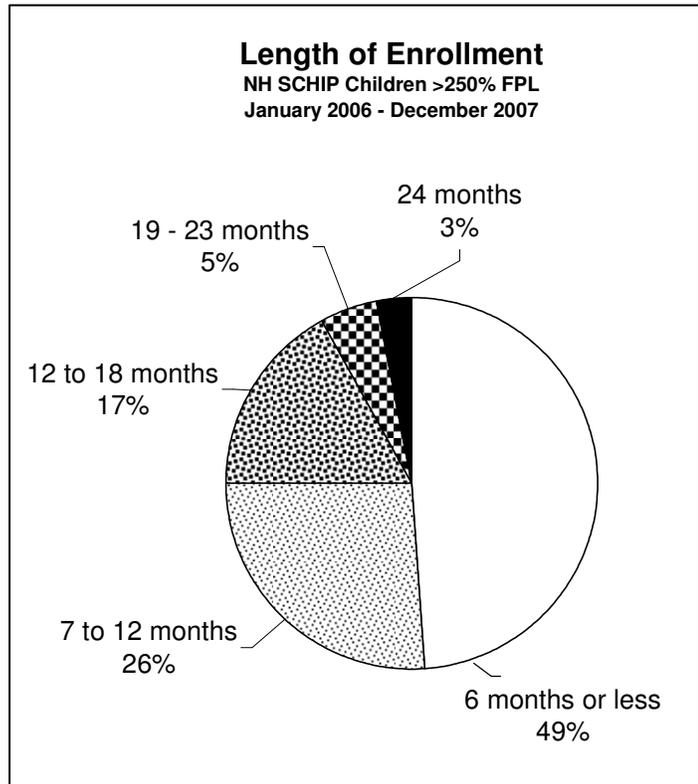
New Hampshire understands the importance of ensuring that public coverage is not substituted for private coverage. Eligibility criterion disallows the substitution of public coverage for private coverage by targeting uninsured children. However, we recognize that certain circumstances are beyond the control of families and warrant exceptions. It is not right to deny healthcare to a child if their parent loses a job involuntary or worse if a child loses a parent. Our policies have been effective. This is substantiated by the fact that employer-based coverage of kids remains high while enrollment in Medicaid and SCHIP has increased over time as shown in these graphs. This experience clearly illustrates that SCHIP in New Hampshire has not resulted in an erosion of private coverage that the directive claims it must remedy.



The directive will have even greater implications because it eliminates the use of deductions from income such as childcare expenses which have long been standards in Medicaid. Having consistent deductions for Medicaid and SCHIP streamlines the eligibility process and lessens complexity in the design of eligibility systems. So while twenty-eight percent (28% or 2,200) of New Hampshire children enrolled in SCHIP have income above 250% FPL, an estimated seventeen percent (17% or 1,300) of enrollees with adjusted family income below 250% FPL would also be affected because these deductions are no longer allowed. Altogether, the directive impacts almost half of New Hampshire SCHIP kids.

Assertions that currently enrolled kids are not affected by the directive put forth false expectations about its true impact. This directive will rapidly decimate the top premium tier of New Hampshire's SCHIP program and result in an increase in the number of uninsured children.

This is inevitable because at higher eligibility levels SCHIP provides transitional coverage for families who experience a disruption in employment and income. As such, it provides vital continuity of care for children who would otherwise be uninsured and offers financial relief and security to their families at a time they need it most. This chart shows that in 2006 and 2007, seventy-five percent (75%)



of families with income above 250% FPL were enrolled for twelve months or less. Only three percent (3%) of children were enrolled for the full twenty-four months. New Hampshire's SCHIP program serves these working families by effectively creating a bridge between the public and private markets.

Despite the short duration of enrollment, overall enrollment in this group has remained consistent over the past few years, meaning that as children transition off, new children enroll to take their place. Immediately upon compliance with the CMS directive, this option will no longer be available to new families who need the program. In two years, we would anticipate that only a handful of children would remain enrolled at this level. The lack of SCHIP coverage for

families who find themselves displaced in the private market will directly result in an increase in the number of uninsured children in New Hampshire by at least 18%. The full impact is not known as there is insufficient data to estimate how many more children would be denied access because they have not been uninsured for a full year or because their families cannot afford cost-sharing comparable to the private market.

Like many states, New Hampshire's state budget is in trouble. The Governor anticipates a \$50 million deficit and the Commissioner of Health & Human Services is meeting with key stakeholders this afternoon to begin the process of determining how his department's forty three percent (43%) share of that deficit can be addressed. ***There are no surplus state dollars that can be used as a stop gap to replace federal funds if this directive is allowed to stand.***

Faced with the diminishing prospects of a timely SCHIP reauthorization that would address the directive, New Hampshire has begun planning the complex tasks associated with complying with the directive. ***Compliance will be extremely costly and administratively burdensome for states.*** Making extensive eligibility system changes, retraining eligibility and outreach workers, reprinting public education materials, re-tooling websites, conducting outreach to community partners, and communicating with families will be confusing, expensive and time-consuming.

While some hold hope that at worst the directive will be temporary, there is simply no logic or value in the wasted effort, cost and disruption to families that would occur in the interim. Despite claims to the contrary, the directive will impact kids. It has already done so in states that filed plan amendments that have been subsequently denied by CMS based on the directive. And it will affect children who lose private coverage through no fault of their own and are unable to access the program because of the forced changes in eligibility. The result will be an increase in

the number of uninsured children and thus an increase in the number of children who go without needed healthcare services.

States need the predictability of a full SCHIP reauthorization to move forward in covering kids. ***In the meantime, Congress must take action – to assure that New Hampshire and other states can continue to operate their highly successful programs under rules put into place a decade ago – by placing a moratorium on the directive.***

On another front, the CHIPRA bill would also have eased the administrative barriers and unintended consequences of the new requirements for verifying citizenship and identify imposed by the Deficit Reduction Act (DRA) of 2005. When the so-called “CIT-DOC” rules went into effect, New Hampshire had in place a functioning system for verifying citizenship of applicants. This system has been disrupted by additional, unnecessary federal requirements which have essentially stalled our momentum in covering kids.

It is important to point out that the “CIT-DOC” requirement did not change the way that immigrant children prove eligibility. The brunt of the impact is being felt by citizen children. Under the new CMS rules, a U.S. birth certificate is not sufficient to prove citizenship and identity. Children who don’t have passports must provide separate documents to prove identity. School or medical records are the only options for proving the identity of children under the age of 16. Thus, the administrative burden is spread to schools and healthcare providers and delays in obtaining documents often mean that families can’t meet processing deadlines. The impact of the CIT-DOC requirement on New Hampshire has been substantial even though our state was one of a few that continued to require citizenship verification when the new rules went into effective.

The addition of identity verification has negatively impacted New Hampshire’s application process and stalled enrollment growth. Before the CIT-DOC requirement, about one-third of

applications were received with all documents needed to verify eligibility. Immediately after the new requirement was put into place, the completion rate dropped, by half, to about 16%. This means more follow-up by staff, longer delays in the eligibility process and ultimately an increase in applications that cannot be processed. The percentage of applications closed for missing verifications jumped from about 10% to 16% of applications. The end result is that fewer eligible children are getting through the process, the administrative burden is higher, the backlog in processing applications is larger and eligible children are going without needed healthcare services. In the year the following the implementation of the new requirement, our Medicaid program of some 63,000 kids grew by only 519 children or less than 1%, compared to 4% and 8% in the previous two years, respectively. CHIPRA would have given states new options to verify citizenship and identity that hopefully would have ameliorated this problem.

Before I close, it is worth highlighting several positive components of the CHIPRA bill that would have expanded children's health coverage and advanced quality of care and cost-effectiveness.

The CHIPRA bill was very thoughtful in giving states not only new tools and resources to be more effective in reaching out to uninsured children but also incentives to encourage the implementation of best practices in outreach and application assistance. Additionally, the bill looked beyond providing an insurance card to assuring that kids receive appropriate, cost-effective services to stay healthy. The development of consistent measures that would help identify opportunities for improvement, coupled with incentives for carrying out those improvements, were essential components of the bill.

But rather than move forward, states have been put on the defensive by CMS. Actions by the administration will force states to cut back their programs and add more complexity to pro-

gram administration. Such rules make it harder for families to enroll and retain their coverage. These actions are completely out of the step with the sentiment of the American people. Overwhelming majorities of voters and residents across American and in New Hampshire resoundingly believe that as a nation and as states we must do more, not less, to provide health coverage to our children. In the world's wealthiest nation, how can we justify that nine million American children do not have access to the healthcare they need to grow and learn and become productive citizens tomorrow?

In closing, let me reiterate that states need the predictability of SCHIP reauthorization and the many positive provisions of CHIPRA to move forward in covering children. Without a successful reauthorization however a number of states are faced with sliding backwards unless Congress takes swift and decisive action by placing a moratorium on the CMS August 17 directive.

Thank you.